Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RENAISSANCE HOSPITAL HOUSTON
C/0 BURTON & HYDE, PLLC
311 WEST 5TH STREET SUITE 100
AUSTIN TX 78701

Respondent Name

DALLAS NATIONAL INSURANCE CO

Carrier's Austin Representative Box

Box Number: 20

MFDR Tracking Number

M4-07-3338-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Requestor respectfully requests the Medical Fee Dispute Officer accept this Amended Position Statement in the above referenced and pending medical fee dispute. It is necessary and proper to update the file because the Requestor has a new attorney of record after the health care provider was placed in bankruptcy… Texas law requires fair and reasonable reimbursement for this hospital outpatient admission. Fair and reasonable reimbursement shall ensure similar procedures provided in similar circumstances received similar reimbursement. Therefore, the fair and reasonable reimbursement amount for this hospital outpatient admission should at least be commensurate with the average amount paid by all insurance carriers in the Texas workers' compensation system in the same year as this admission for these admissions involving the same Principal Diagnosis Code and Principal Procedure Code… In the alternative, it is also justifiable to order as much in additional reimbursement as is owed under the Hospital Facility Fee Guidelines – Outpatient because the Division's new fee guidelines, while not in effect at the time, are presumptively fair and reasonable reimbursement under the law and data from the Medicare Outpatient Prospective Payment system for these dates of service is still available for calculating the amount due… Texas law requires fair and reasonable reimbursement for this admission because medical reimbursement for health care not provided through a workers' compensation health care network. There was no fee guideline for hospital outpatient admissions at the time the hospital billed for these services. The hospital did not have a negotiated contract with the carrier. Therefore, the health care provided by Renaissance Hospital – Dallas to [injured employee] should be reimbursed at a fair and reasonable amount."

Amount in Dispute: $4,383.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The EOBs provided herein demonstrate the Responding party reimbursed the Requesting Party at a reasonable rate when considering the benchmarks and geographic considerations and the rules with respect to bundled and unbundled services. The charges for the medical services submitted by the Requestor exceeded the reasonable rate for reimbursement and therefore did not further the end of achieving effective medical cost control. Responding Party further asserts that some of the charges have already been reimbursed as being included in the allowance for another service. Consequently the requested reimbursement is unreasonable and unnecessary. The Requesting Party asserts the reimbursements for the charges for medical

reflected above were inappropriately reduced. However Responding Party counters that the EOBs attached herewith reflect an appropriate fee reduction pursuant to the State Guidelines. Respondent further asserts the Requestor has not provided any reasonable medical documentation establishing a basis for deviating or exceeding the State Guid3elines. Consequently pursuant to Texas Labor Code Section 413.031 the Requestor cannot carry their burden."

Response Submitted by: Lewis & Backhaus, PC, 14160 Dallas Parkway, Suite 400, Dallas, Texas 75254

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 25, 2006	Outpatient Surgery	$4,383.10	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 TexReg 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. This request for medical fee dispute resolution was received by the Division on January 22, 2007.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 600 – Reimbursement based on usual, customary and reasonable for this geographic region.
   - 97 – Payment is included in the allowance for another service/procedure.
   - W10 – No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier.
   - L01 – Recommended allowance is considered fair and reasonable
   - L02 – Fair & reasonabler based on comparison of services performed & reimbursed in your geographical area.
   - XL03 – Charge is considered inclusive in the fair and reasonable recommended allowance.
   - W2 – Workers compensation claim adjudicated as non-compensable. Carrier not liable for claim or service/treatment.

Findings

1. The initial EOB dated April 17, 2006 denied the treatment/services using denial code "W2 – Workers compensation claim adjudicated as non-compensable. Carrier not liable for claim or service/treatment." However, the reconsideration EOB with a date paid of May 12, 2006 issued payment of $1,318.70; therefore, the disputed treatment/services will be review in accordance with the Texas Labor Code and Division rules.
2. 28 Texas Administrative Code §133.307(c)(2)(E), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include "a copy of all applicable medical records specific to the dates of service in dispute." Review of the submitted documentation finds that the requestor has not provided copies of all medical records pertinent to the services in dispute. Although the requestor did submit a copy of the operative report, the requestor did not submit a copy of the anesthesia record, post-operative care record, or other pertinent medical records sufficient to support the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(E).
3. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that

discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:

- The requestor's position statement asserts that "Texas law requires fair and reasonable reimbursement for this hospital outpatient admission. Fair and reasonable reimbursement shall ensure similar procedures provided in similar circumstances received similar reimbursement."
- Documentation of the comparison of charges to other carriers was not presented for review.
- Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
- The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 TexReg 6276 (July 4, 1997). It further states that "Alternative methods of reimbursement were considered… and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges…" 22 TexReg 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 23, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.